Department of LABOR AND INDUSTRIES

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PROVIDER BULLETIN

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THIS ISSUE

Chronic Pain Management Program

TO:

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Chiropractor
Hospital Full Care
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Purpose

The purpose of this bulletin is to explain revisions the department recently made to its policies concerning the authorization and payment of chronic pain management programs. This bulletin replaces Provider Bulletin 93-02.

Specifically, the revisions to the chronic pain management program include:

- Eliminating the current chronic pain management program contracts,
- Establishing an all inclusive, phase-based, per diem fee schedule,
- Establishing a per diem fee schedule for inpatient room and board services, and
- Authorizing the extension of the treatment phase using specific criteria.

In addition to these revisions of the chronic pain management program, disability prevention evaluations by chronic pain management programs will be eliminated.

What is Changing?

Since 1987, the department has authorized and paid for chronic pain management programs by contract. Effective February 1, 2005, these contracts will be eliminated and replaced by a fee schedule payable to any chronic pain management program meeting the provider requirements. This fee schedule will be all-inclusive, paid by chronic pain management phase, and is based on a daily rate.

This bulletin provides **New Maximum Allowable Fees and Billing Codes** for chronic pain management programs. These fees will be effective for dates of service on or after February 1, 2005.

When should an injured worker be referred for a chronic pain management program evaluation?

When the attending physician (AP) requests a referral to a chronic pain management program, the claim manager may authorize an evaluation if the injured worker has chronic pain, is **not** a surgical candidate, and meets one of the following criteria:

- Has received conservative treatment for approximately six months without significant improvement, has a perceived degree of pain, and has not returned to work, or
- Has not significantly improved or has not returned to work due to pain within approximately six months following authorized surgery, or
- Has significant pain medication abuse problem, or
- Has returned to work, but needs help with chronic pain management.

What are the chronic pain management program phases and the fee schedule?

A chronic pain management program has an interdisciplinary team who provides appropriate services to rehabilitate persons with chronic pain. Multiple modalities address the psychosocial and cognitive aspects of chronic pain behavior together with physical rehabilitation.

A chronic pain management program consists of three phases with a separate fee schedule for each phase. The chronic pain management program phases are defined as:

- Evaluation Phase. This phase consists of an initial evaluation including at a minimum a medical examination, psychological evaluation, and a vocational assessment. A summary evaluation report is required and must include information from each discipline participating in the evaluation and a return to work action plan. This phase lasts one to two days.
- Treatment Phase. At a minimum, this phase consists of medical management, psychiatric testing and/or counseling, physical and occupational therapy, and vocational rehabilitation services with return to work goals as indicated. Other services provided in this phase may vary as required by the need of the injured worker. A discharge report is required and must include the findings of each discipline involved in the treatment phase and must list the outcome of the treatment. The maximum duration of this phase is 18 treatment days. The 18 treatment days are consecutive[1] with each treatment day lasting 6-8 hours.
- Follow-Up Phase. This phase will consist of remedial treatment or status checks as needed to determine how well the injured worker is coping following completion of the treatment phase. The goal is to extend and reinforce the gains made during the treatment phase. This phase is not intended to be a substitute for or serve as a second treatment phase. A follow-up report is required including the findings of all disciplines involved in providing the follow-up services. This phase will last for no more than a total of five follow-up days during the three months immediately following completion of the treatment phase or treatment phase extension.

[1] This does not normally include weekends and holidays.

The reports required for each phase must be sent to the department and to the attending physician. When requested, other reports (i.e. weekly updates) may be required.

The fee schedule and procedure codes for these phases are listed in the following tables. This fee schedule applies to injured workers in either an outpatient or inpatient program.

The current local codes used for billing pain clinic contract services (2000M, 2001M, and 2002M) will be invalid for dates of service after January 31, 2005. Outpatient chronic pain management programs will bill using the new local codes listed in the following table on a CMS-1500 (HCFA) form. The new codes and fees will be effective February 1, 2005. These fees may be adjusted annually when the department publishes its fee schedule.

Description	Local Code	Duration	Fee Schedule
Pain Clinic Evaluation	2010M	Conducted over 1-2 days	$1,007.00
Pain Clinic Treatment	2011M	Not to exceed 18 treatment days	$645.00 per day
Pain Clinic Treatment Extension	2012M	Not to exceed 10 treatment days	$645.00 per day
Pain Clinic Follow-Up	2013M	Not to exceed 5 follow-up days	$277.25 per day

Facility based chronic pain management programs will bill using the revenue codes listed in the following table on a CMS-1450 (UB-92) form, effective February 1, 2005.

Description	Revenue Code	Duration	Fee Schedule
Pain Clinic Evaluation	0011	Conducted over 1-2 days	$1,007.00
Pain Clinic Treatment	0012	Not to exceed 18 treatment days	$645.00 per day
Pain Clinic Treatment Extension	0017	Not to exceed 10 treatment days	$645.00 per day
Pain Clinic Follow-Up	0013	Not to exceed 5 follow-up days	$277.25 per day

What is a Return to Work Action Plan?

If the injured worker needs assistance in returning to work or becoming employable, the claim manager will authorize admission to the chronic pain management program for treatment after:

- The chronic pain management program vocational specialist (program counselor) and the department assigned vocational rehabilitation counselor (department assigned counselor) have agreed upon a return to work action plan with a return to work goal acceptable to the department; and

- The AP and the injured worker approve the return to work action plan with a return to work goal.

The return to work action plan is to provide the focus for vocational services during an injured worker's participation in a chronic pain management program. The initial plan is to be submitted with the evaluation report. The department assigned counselor will facilitate the review, revision, and approval of the return to work action plan by the AP and the injured worker. The return to work action plan may be modified or adjusted during the treatment or follow-up phase as needed. At the end of the program the listed return to work action plan outcomes must be included with the treatment discharge report.

An acceptable return to work action plan is a one-page statement (see Appendix A for sample format) included with the chronic pain management program's vocational evaluation report that contains:

- The injured worker's current vocational status with the employer of injury;

- The injured worker's current level of physical function;

- The appropriate U.S. Department of Labor Dictionary of Occupational Titles (DOT) number and physical demands of the job goal common to the immediate labor market; and

- The actions, timelines, and people responsible for achieving the Return to Work Action Plan goal.

Who is involved when a return to work action plan is developed and implemented?

In the development and implementation of the return to work action plan, the program counselor, the department assigned counselor, the AP, and the injured worker are involved. Their specific roles are listed below.

1. The program counselor:
    - Co-develops the return to work action plan with the department assigned counselor.
    - Presents the return to work action plan to the claim manager at the completion of the evaluation phase if the injured worker is recommended for admission for treatment and needs assistance with a return to work goal.
    - Communicates with the department assigned counselor during the treatment and follow-up phases to resolve any problems in implementing the return to work action plan.

2. The department assigned counselor:
    - Co-develops the return to work action plan with the program counselor.
    - Attends the chronic pain management program discharge conference and other conferences as needed either in person or by phone.

- Negotiates with the AP when the initial return to work action plan is not approved in order to resolve the AP's concerns.
- Communicates with the program counselor during the treatment and follow-up phases to resolve any problems in implementing the return to work action plan.
- Implements the return to work action plan following the conclusion of the treatment phase.
- Obtains the injured worker's signature on the return to work action plan.

3. The attending physician:
   - Reviews and approves/disapproves the initial return to work action plan within 15 days of receipt.
   - Reviews and signs the final return to work action plan at the conclusion of the treatment phase within 15 days of receipt.
   - Communicates with the department assigned counselor during the treatment and follow-up phases to resolve any issues affecting the return to work goal.

4. The injured worker:
   - Will participate in the selection of a return to work goal.
   - Reviews and signs the return to work action plan.
   - Shall cooperate with all reasonable requests in developing and implementing the return to work action plan. Should the injured worker fail to be cooperative, the sanctions as set out in RCW 51.32.110 shall be applied.

What is the fee schedule for inpatient room and board costs?

There are occasions when the chronic pain management program evaluation indicates a need for the injured worker to be treated on an inpatient basis. All inpatient admissions will require prior authorization and utilization review. Utilization review for the department is provided by Qualis Health. Eligible providers will contact Qualis Health at 1-800-541-2894 or fax their request to 1-877-665-0383. Qualis Health will compare the injured worker's clinical information to established criteria and make a recommendation to approve or deny the inpatient admissions request to the claim manager. The claim manager will make the final authorization decision. When the claim manager authorizes treatment on an inpatient basis, the provider will be reimbursed up to $458.00 per day for room and board costs. These costs should be billed using either Revenue Code 0129 (semi-private) or 0149 (private). This rate may be adjusted annually when the department publishes its fee schedule.

What if the injured worker needs more treatment than is permitted by the limit established in the fee schedule?

Under certain circumstances, the claim manager can authorize up to 10 additional days of treatment for the injured worker when the worker is progressing steadily but requires additional time to achieve the treatment goals.

The claim manager may authorize the extension after reviewing the request and determining that it meets the extension approval criteria.

The following factors will be applied when evaluating a request for extending treatment:

1. The treatment phase extension is limited to a one-time basis per life of the claim.

2. The extension should be on an outpatient basis. Extension of inpatient services will require concurrence of the respective claims unit ONC based on their review of the extension request and claim file.

3. Extensions are not granted for either the evaluation or follow-up phases.

4. The extension is limited to a specific number of treatment days not to exceed a maximum of 10 consecutive[2] treatment days. The start and end dates must be defined prior to start of the treatment phase extension.

5. The treatment phase extension request must be based on specific issues requiring further treatment. The request must be supported by documentation of progress made to date in the program.

6. The request must clearly state the goals of the treatment phase extension and time needed to meet those goals.

What are the criteria for extending the treatment phase?

Before the claim manager authorizes the treatment phase extension, one or both of the following criteria must be documented in the extension request:

1. Treatment is steadily progressing toward achievement of a treatment goal and how the extension supports meeting that specific treatment goal.

2. The injured worker is nearing completion of treatment and needs a few more sessions to achieve the treatment goal.

Who is eligible to provide chronic pain management program services to injured workers?

In order to be eligible to provide chronic pain management program services to injured workers, the Commission on Accreditation of Rehabilitation Facilities (CARF) must accredit the provider as an interdisciplinary pain rehabilitation program.

The term interdisciplinary is meant to describe the type of program and is not meant to define the practice skills of staff members. It is the department's expectation that providers of chronic pain management program services work within the scope of practice for their specialty and/or be appropriately certified or licensed for the field in which they work (i.e., biofeedback technician maintains certification, nurse maintains current license, vocational rehabilitation counselor maintains department registration, licensed psychologist/psychiatrist supervise and interpret psychological testing, and licensed medical providers supervise medical management).

Providers must maintain their CARF accreditation and provide the department with documentation of satisfactory recertification. The respective provider account will be inactivated if CARF accreditation expires. It is the provider's responsibility to notify the department when an accreditation visit is delayed for administrative reasons.

[2] This does not normally include weekends and holidays.

What if a CARF accredited provider is not reasonably available for injured workers who have moved out of Washington State?

In certain circumstances, a CARF accredited provider may not be reasonably available to the injured worker's home. In those circumstances, a provider with CARF-like credentials may provide chronic pain management program services to the injured worker.

For outpatient services, these CARF-like credentials include:

- Patient pre-screening is conducted by a physician, psychiatrist/psychologist, physical/occupational therapist, and a vocational rehabilitation counselor at a minimum.
- Regular interface occurs between a physician and the injured worker on a frequent if not daily basis during treatment.
- Treatment includes, at a minimum, medical management, psychiatric testing and/or counseling, physical and occupational therapy, and vocational rehabilitation services with return to work goals as indicated.
- Follow-up includes remedial treatment or status checks to determine how well the injured worker is coping following completion of their treatment.

For inpatient services, these CARF-like credentials include:

- The outpatient services credentials listed above, and
- Affiliation with a Joint Commission on Accreditation of Healthcare Organizations (JACHO) accredited hospital.

CARF-like providers will be required to comply with the chronic pain management program policies and fee schedule as well as meet the same reporting requirements as CARF accredited programs. CARF-like providers must also obtain a department provider account number. The provider account number for CARF-like providers will be activated for only nine (9) months.

If an injured worker does not complete a full day of treatment or follow-up, how do I bill for those services?

It is the department's expectation that the injured worker will be in attendance for the full 6-8 hours each treatment day during the treatment phase. If the injured worker is unable to complete a full day of treatment due to an emergency or unforeseen circumstances, the provider should bill for that portion of the treatment day completed by the injured worker.

For example, Clinic A requires the injured worker to be in attendance for 8 hours for each treatment day. The injured worker had an unforeseen emergency and had to leave the clinic after 2 hours (25% of the treatment day) of one treatment day. The clinic would bill the department for that day as follows: $645.00 x 25% = $161.25.

For the follow-up phase, the provider should bill for that portion of the follow-up day that the injured worker is in attendance.

For example, Clinic B scheduled the injured worker for 3 hours of follow-up services. Clinic B's normal hours of attendance for the injured worker are 6 hours. Clinic B would bill the department for those 3 hours of follow-up services as follows: $277.25 x 50% = $138.63.

Why are Disability Prevention Evaluations being discontinued?

The purpose of the disability prevention evaluation is to obtain treatment and/or vocational recommendations when treatment or vocational efforts are stalled. These evaluations are very similar in nature to the chronic pain management program evaluations. The same specialties are involved in both the disability prevention evaluation and the chronic pain management program evaluation.

The department's utilization of disability prevention evaluations has steadily declined over the past several years. Based on this steady decline in the number of referrals for disability prevention evaluations and the close similarity to the chronic pain management program evaluation, there does not appear to be a need to continue authorizing the disability prevention evaluations.

Therefore, authorization for disability prevention evaluations will be terminated and their local codes 2003M and 2004M will be invalid for dates of service after January 31, 2005**.**

Where can I find out any additional information about the chronic pain management program or disability prevention evaluations?

Additional information can be found at the Labor & Industries website: http://www.lni.wa.gov/Main/Provider Topics.asp and in Claims Administration Policy 7.06 "Authorizing Worker Participation in Pain Programs".

Appendix A
Return to Work Action Plan

Date: _____/_____/_____ Injured Worker's Name: _____
Claim Number: _____

Vocational Status Early Intervention ☐ Ability to Work Assessment ☐ Plan Development ☐ Plan Implementation ☐
Current Physical Capacities (Use D.O.T. Strength Factors)
Return to Work Goal(s) (Listed in priority order) **Physical Demand of Return to Work Goal(s)**
Actions, Timelines, and Responsibilities:

_____ ____/____/____ _____ ___/____/___
Program Counselor Date Program Medical Director Date

_____ ___/___/___ _____ ___/___/___
Dept. Assigned Counselor Date Attending Physician Date
Agree ____ Disagree _____

_____ ___/___/___
Injured Worker Date